MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02727

CERTIFICATE OF DEATH

Reg. Diat. No. 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles M. Ashbaugh

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of ~~husband~~ or wife: late Elsie J. Clem

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 25 - 1862

8. AGE:

Years	Months	Days	If less than one day
82	2	12	hrs. min.

9. Birthplace: Frederick County, Md.

(Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business: Retired

FATHER

12. Name: Jacob Ashbaugh

13. Birthplace: Maryland

MOTHER

14. Maiden name: Not

15. Birthplace: Known

16. Informant: Raymond H. Ashbaugh

Address: Hagers, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Mar. 15-1945 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Hagers, Md.

18. Funeral director: Powell & Hartzler

Address: Woodsboro, Md.

19. March 13 1945 (Date rec'd by registrar) Chas S Bineday Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1945 at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1943 to Mar 12 1945

and that I last saw h~~im~~er alive on Mar 12 1945

	DURATION
Immediate cause of death: Arteriosclerotic C-V disease	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T Marsh M. D.

M. D. or other

Address: New Windsor Md Date signed: 3/13/45

Evidence for change of age is shown on FILM No. G 9 4 MAY 11 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02728

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 15 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worchester
City or town: Newark
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ELLA ELLEN AYERS

3.(b) Social Security Number: 219-07-6860

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: John Ayers
6.(c) If alive, give age: 40 years
7. Birth date of deceased (mo., day, yr.): Febuary 5, 1905

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
40 ~~39~~	0	27		

9. Birthplace: Newark, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at home

FATHER
12. Name: Levin Johnson
13. Birthplace: Mt. Westley, Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 8 1945 (month) (day) (year)
Cemetery or crematory: Snow Hill Cem.
Location: Snow Hill, Md.
18. Funeral director: Kearney & Dennis
Address: Snow Hill, Md.

19. 3/4 (Date rec'd by registrar) 19 45 Albert R. Truitt Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4, 19 45 at 10.35P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 17, 19 43 to March 4, 19 45 and that I last saw her alive on March 4, 19 45

Immediate cause of death	DURATION
Peritonitis	Oct. 1942
Due to	
Due to	
Other conditions: Tuberculous Pleurisy	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 3/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

02729

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 WEEKS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: RURAL WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ROUTE
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SAMUEL NELSON BAKER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: LULA BAKER

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): JULY 20, 1864

8. AGE:

Years	Months	Days	If less than one day
80	8	2	...hrs. ...min.

9. Birthplace: BALTIMORE COUNTY, MD.
(Town, county, and state)

10. Usual occupation: FARMER

11. Industry or business

FATHER
12. Name: WILLIAM BAKER
13. Birthplace: MD

MOTHER
14. Maiden name: MARGARET MASEMORE
15. Birthplace: MD.

16. Informant: MRS. HARRY OGG

Address: WESTMINSTER, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 3/25/45 (month) (day) (year)

Cemetery or crematory: MIDDLETOWN CEM.

Location: MIDDLETOWN, MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 3/23 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 22 1945, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 14 1945, to Mar 22 1945 and that I last saw him alive on Mar 21 1945

Immediate cause of death	DURATION
Acute Cardiac Dilatation	4 hrs.
Due to: Chronic Myocarditis	4 yrs.
Due to: Chronic Interstitial nephritis	3 yrs.
Other conditions: Chronic Arteriosclerosis	8 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas R Fauntz MD
M. D. or other

Address: Westminster Md Date signed 3/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

02730

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL WESTMINSTER #4
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: RURAL WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ROUTE 4
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN W. H. BLACK

3.(b) Social Security Number: 213-05-1703

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ABOUT 1875

8. AGE: Years	Months	Days	If less than one day
ABOUT 70			hrs. min.

9. Birthplace: SILVER RUN, MD.
(Town, county, and state)

10. Usual occupation: LABOR (RETIRED)

11. Industry or business

FATHER
12. Name: WILLIAM BLACK
13. Birthplace: MD.

MOTHER
14. Maiden name: MARY A. MILLER
15. Birthplace: MD.

18. Informant: GEORGE C. BLACK

Address: WESTMINSTER, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 3/20/45 (month) (day) (year)

Cemetery or crematory: WESTMINSTER CEMETERY

Location: WESTMINSTER, MD

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 3/17 19 45 E. K. Woodward Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 16 19 45, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Arteriosclerotic C-V disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Shanck, Deputy Medical Examiner
M. D. or other

Address: Westminster, Md. Date signed: 3/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02731

CERTIFICATE OF DEATH

Reg. Diat. No. 74

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 7 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Ruxton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Emanuel Booker

3. (b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Evelyn Booker

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): November 21, 1911

8. AGE: Years	Months	Days	If less than one day
33	3	9	hrs. min.

9. Birthplace: Prince Edward County, Va. (Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business

FATHER
12. Name: William Booker
13. Birthplace: Prince Edward County, Va.

MOTHER
14. Maiden name: Elizabeth Watkins
15. Birthplace: Prince Edward County, Va.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/5/45 (month) (day) (year)
Cemetery or crematory: Arbutus Mem. Park
Location: Balto. Md.

18. Funeral director: Mrs Ger. H. Holland
Address: 1631 Druid Hill Ave.

19. 3/2 (Date rec'd by registrar) 19 45 Albert R. [illegible] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2, 1945, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Janurary 23, 1945 to March 2, 1945 and that I last saw him alive on March 2, 1945

Immediate cause of death	DURATION
Peritonitis	12/8/44
Due to: Ruptured Appendix	
Due to:	
Other conditions: Pulmonary Tuberculosis	Aug. 1941

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed 3/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

02732

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 N. George
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME James H. Bowers

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Elizabeth R. Shettle
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 12 - 1857

8. AGE:

Years	Months	Days	If less than one day
88	2	13	..... hrs. ..... min.

9. Birthplace Littlestown, Pa.
(Town, county, and state)
10. Usual occupation Farmer - Ret.
11. Industry or business
FATHER 12. Name Josiah Bowers
13. Birthplace md.
MOTHER 14. Maiden name Edlinda ~~Bigle~~ Reigle
15. Birthplace md.
16. Informant Clara Bowers
Address Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 27-1945 (month) (day) (year)
Cemetery or crematory Methodist Cemetery
Location Finksburg, Md.
18. Funeral director H. Bankard Son
Address Westminster Md.
19. 3/26/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945, at 10:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 1945, to March 25 1945
and that I last saw him alive on March 24 1945

	DURATION
Immediate cause of death Pneumonia	2 da.
Lobar & Cardio	1 yr.
Renal disease	
Due to Senility & arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. Glenn Speicher M. D., or other
Address Westminster Md. Date signed 3/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

02733

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mr. Benton Brining

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Clara A. Brining
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1855

8. AGE:	Years	Months	Days	If less than one day
	89	3	26	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation retired druggist
11. Industry or business

FATHER
12. Name Capt. John C. Brining
13. Birthplace Germany

MOTHER
14. Maiden name Katherine Speilman
15. Birthplace Md

16. Informant Mrs. Clara A. Brining
Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 13, 1945 (month) (day) (year)
Cemetery or crematory Lutheran
Location Taneytown, Md.

18. Funeral director C. O. FUSS & SON
Address Taneytown, Md.

19. March 13. 1945 (Date rec'd by registrar) Ethele M. Mehring Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 11th 1945, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 21st 1945, to Mar 11th 1945
and that I last saw him alive on Mar 10th 1945

	DURATION
Immediate cause of death Cerebral Meningitis	8 days
Due to Sp. the lining Nose &	5 yrs
and Wall -	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. N. Bennett M.D. M. D. or other
Address Taneytown Md Date signed 3/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02734

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 5 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Queen Anne

City or town: Barclay

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARY EMMA BROOKS

3.(b) Social Security Number: 219-07-6536

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 7, 1917

8. AGE:

Years	Months	Days	If less than one day
27	7	21	..... hrs. ..... min.

9. Birthplace: Wilmington, Del. (Town, county, and state)

10. Usual occupation: Defence Worker

11. Industry or business

FATHER

12. Name: Perry Brooks

13. Birthplace: Perrysville, Md.

MOTHER

14. Maiden name: Mary Spencer

15. Birthplace: Sudlersville, Md.

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3-30-45 (month) (day) (year)

Cemetery or crematory: Ford Town, Conn.

Location: Ford Town, Conn.

18. Funeral director: Francis F. Hensel

Address: 518 W. Biddle St

19. 3/28 (Date rec'd by registrar) 45 Albert R. Shankhorn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28, 1945, at 10.00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23, 1944, to March 28, 1945 and that I last saw her alive on March 28, 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	March 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md. Date signed 3/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

02735

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?:
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 22 Lafayette Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: IRENE BROWN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Joseph Brown
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): October 17, 1886

8. AGE: Years	Months	Days	If less than one day
58	4	24	....hrs. ....min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at home

FATHER
12. Name: William Pinkney
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Julia Wallace
15. Birthplace: Annapolis, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/16/45 (month) (day) (year)
Cemetery or crematory: Brewers Hill
Location: Annapolis, Md
18. Funeral director: Ethel L. Hughes
Address: 45 N. West St. Annapolis Md.

19. 3/13 (Date rec'd by registrar) 19 45 Albert R. Saunders, Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13, 19 45 at 4.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12, 19 45 to March 13, 19 45 and that I last saw her alive on March 13, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1940
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Md. Date signed: 3/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

02736

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hauckstoille
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hauckstoille.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary S Buchman
3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widow

6.(b) Name of husband or wife: John W Buchman
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Sept 24 - 1866

8. AGE:

Years	Months	Days	If less than one day
78	5	18	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: John Stump
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Kopp
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs Ged Shafer
Address: Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 14 45 (month) (day) (year)
Cemetery or crematory: Hampstead
Location: Hampstead Md
18. Funeral director: Edw C Upton
Address: Hampstead Md
19. Mar 13 19 45 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 19 45 at 8:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 45 to March 12 19 45
and that I last saw him alive on March 11 19 45
Immediate cause of death: Coronary Thrombosis — DURATION: 1 hr.
Due to: Hypertension, Essential — DURATION: 15 yrs.
Due to: — DURATION:
Other conditions: — DURATION:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Cartzendafner M.D.
M. D. or other
Address: Hampstead Md Date signed: 3-13-45

02737

Evidence for addition of residence of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

FILM N G 94 MAY 15 1945

Reg. Dist. No. 70

1. PLACE OF DEATH:
County Carroll
City or town Mayberry
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death 50 y
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #7
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Margaret A. Earl

3. (b) Social Security Number none

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife John Earl
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) April 26, 1857
8. AGE: Years 87 Months 10 Days 18 If less than one day ..... hrs. ..... min.
9. Birthplace Md (Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name John Stonaker
13. Birthplace Pa
MOTHER 14. Maiden name Susan A. Eckard
15. Birthplace Pa
16. Informant Lloyd R. Earl
Address Westminster, R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 19, 1945 (month) (day) (year)
Cemetery or crematory Church of God
Location Mayberry, Md.
18. Funeral director C. E. Buss & Son
Address Taneytown, Md.
19. March 17 1945 (Date rec'd by registrar) Ethele M. Mehring Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945 at 12:15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1939 to March 16 1945 and that I last saw h.e alive on March 15 1945

	DURATION
Immediate cause of death: Bronchopneumonia (Secondary)	2 days
Due to: Acute Bronchitis and Coryza	11 days
Due to:	
Other conditions: Pleurisy (Non-Tuberculous)	5 days
Chronic Nephritis, Chronic Myocarditis	20 yrs.
(Include pregnancy within 3 months of death) General Arteriosclerosis	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D. M. D. or other
Address Taneytown Md Date signed 3/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02738

Reg. Dist. No. 80

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lewis Philip Crawmer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of ~~husband or~~ wife: late Elizabeth Crawmer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 20 - 1869

8. AGE:

Years	Months	Days	If less than one day
75	4	19	hrs. min.

9. Birthplace: Carroll County Md.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER

12. Name: Jesse Crawmer

13. Birthplace: Maryland

MOTHER

14. Maiden name: Annie Beech

15. Birthplace: Virginia

16. Informant: Earl F Crawmer

Address: New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 14 - 1945 (month) (day) (year)

Cemetery or crematory: Western Cemetery

Location: Union Bridge Road

18. Funeral director: H. H. Shriver & Sons

Address: Union Bridge & New Windsor, Md.

19. March 12 1945 Ernest Shank

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1945 at about 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Hanging by the neck.	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: Mar 11 - 45

Where did injury occur? New Windsor (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Hanging by neck Injured at work? No.

23. SIGNATURE: James T. Thorne, Deputy Medical Examiner

M. D. or other

Address: New Windsor Md Date signed: 3/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING (Ink) Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 552 ✓

02739

CERTIFICATE OF DEATH

Reg. Diat. No. 79

1. PLACE OF DEATH:
County Carroll
City or town Keymar Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Middleburg District
(If outside city or town limits, write RURAL and give nearest town)
Street No. Key Mon Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME H. Frank Delaplane

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Alice E. Delaplane
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 22, 1871

8. AGE: Years 73 | Months 11 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name James Delaplane
13. Birthplace Md

MOTHER 14. Maiden name Alice Wagner
15. Birthplace Md

16. Informant Mrs Alice E. Delaplane
Address Keymar, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Mar 7 1945 (month) (day) (year)
Cemetery or crematory Haugh's
Location Mr. Ladiesburg Md

18. Funeral director Ed Diggs & Son
Address Taneytown, Md

19. Mar 7 1945 (Date rec'd by registrar) Chas A Diggs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1945, at 11:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Mar 5 1945 and that I last saw h alive on Mar 5 1945

Immediate cause of death	DURATION
Sarcoma of L. with Metastasis to lungs and the abdomen	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. A. Mussler M.D.
M. D. or other

Address Johnsville Md Date signed Mar 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2) V

02740

CERTIFICATE OF DEATH

Reg. Diat. No. 71

1. PLACE OF DEATH:
County: Carroll
City or town: Uniontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Uniontown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Luella Stevenson Weilbiss

3.(b) Social Security Number: none

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband ~~or wife~~: Snader Weilbiss
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct. 26 - 1863
8. AGE: Years: 81 Months: 4 Days: 16 If less than one day: ..... hrs. ..... min.
9. Birthplace: Carroll County, Md.
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business:
FATHER 12. Name: Leonard Zile
13. Birthplace: Maryland
MOTHER 14. Maiden name: Margaret Stevenson
15. Birthplace: Maryland
16. Informant: Snader Weilbiss
Address: Uniontown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 16-1945 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Uniontown, Md.
18. Funeral director: C. M. Hartsler Sons
Address: Union Bridge & New Windsor, Md.
19. March 13 1945 Margaret R. Englar
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13- 1945, at 2:12 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 2 1945, to Mar. 13 1945
and that I last saw her alive on March 12 1945

	DURATION
Immediate cause of death: Accident - Fracture Fr. Spine	
Due to:	
Due to: Carcinoma Peritoneum	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Hugg M. D. or other
Address: Union Bridge Date signed: 3/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

02741

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yr 6 mo 24 da

Hospital, Institution, or street address where death occurred Springfield State Hospital

How long in hospital or institution? 3 yr 6 mo 24 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Carroll

City or town Westminster (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Isabelle Diser

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 1st 1856

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
88	6	25		

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden name unknown.

15. Informant Carrella Hesse for Aged 16. Address Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 29 1945 (month) (day) (year)

Cemetery or crematory Westminster

Location Westminster, Md

18. Funeral director H. Bankard & Son Address Westminster, Md

19. Mar. 26 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945 at 7-45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 d 1941 to Mar 26 1945

and that I last saw h... alive on Mar 26 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 da
Due to Sent Arteri Sclerosis	10 yr
Due to Chr. Myocarditis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE W. F. Waston M.D. M. D. or other

Address Sykesville Md Date signed 3/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-6) ✓

CERTIFICATE OF DEATH

0274276

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Westminster R.D.7

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster R.D.7

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Emory town road near Westminster

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Mollie Alice Engler

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Samuel Ellsworth Engler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 11, 1875

8. AGE: Years	Months	Days	If less than one day
70	2	13	..... hrs. ..... min.

9. Birthplace: New Westminster Carroll Co. Md.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Noah Bigler

FATHER 13. Birthplace: Md.

MOTHER 14. Maiden name: Sarah Myers

MOTHER 15. Birthplace: Md.

16. Informant: Mrs. Edna P.A. Beard

Address: Westminster R.D.7 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 27/45 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Uniontown Carroll Co. Md.

18. Funeral director: J. E. Myers Jr.

Address: Westminster Md

19. 3/26 19 45 [signature] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 19 45 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1 19 43, to Mar. 24, 19 45

and that I last saw h.e. alive on Mar 24 19 45

Immediate cause of death	DURATION
Metastatic Cancer of Lungs	3 mos.
Due to Carcinoma of Uterus	not known
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. Reese Wilkens M.D.

M. D. or other

Address: Westminster Date signed: 3/26/45

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

02743

CERTIFICATE OF DEATH

FILM No. G 9 4 MAY 15 1945

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Taneytown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mos 5 da
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 7 mos 5 da

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State: Md County: Montg
City or town: Bethesda Md (If outside city or town limits, write RURAL and give nearest town)
Street No. 4935 Del Ray ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Getzendanner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: —
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Oct 16th 1870

8. AGE: Years: 74 73 | Months: 5 | Days: 9 | If less than one day: ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: housework
11. Industry or business: at home
12. FATHER Name: Charles A Buffat
13. Birthplace: Maryland
14. MOTHER Maiden name: Elizabeth Adams
15. Birthplace: Maryland
16. Informant: Mrs Elizabeth Compton
Address: 4935 Del Ray ave Bethesda
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 28-45 (month) (day) (year)
Cemetery or crematory: Rockville Union
Location: Rockville, Md.
18. Funeral director: Wm Reuben Pumphrey
Address: Bethesda, Md.
19. Mar. 25 1945 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 1945, at 7 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 18th 1944, Mar 25 1945 and that I last saw h alive on mar 25th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 da
Due to	
Due to Cistern Sclerosis	10 yrs
Hypertension	0
Other conditions Diabetes	3

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: Cerebral Hemorrhage
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: H H Watson M.D. M. D. or other
Address: Taneytown Md Date signed: 3/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-B)

02744

CERTIFICATE OF DEATH

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Uniontown - Taneytown Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Oscar Gilbert

3.(b) Social Security Number: 220-16-1975

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence M. Gilbert

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 13 - 1872

8. AGE: Years	Months	Days	If less than one day
72	6	6	..... hrs. ..... min.

9. Birthplace: Carroll County Maryland (Town, county, and state)

10. Usual occupation: Threasherman

11. Industry or business: Farm

FATHER — 12. Name: Samuel Gilbert

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Rebekah Babylon

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs Florence M. Gilbert

Address: Union Bridge, Maryland Route 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 22-1945 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Uniontown, Maryland

18. Funeral director: D. D. Hartle & Son

Address: Union Bridge & New Windsor, Md

19. March 20, 1945 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1945 at 6 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to Mar 18 1945 and that I last saw him alive on Mar 13 1945

Immediate cause of death	DURATION
Congestive Heart	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Date signed: 3-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-6)

CERTIFICATE OF DEATH

02745 74
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 6 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 year, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Arthur Grove, Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Louise Heller
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 21, 1896

8. AGE: Years	Months	Days	If less than one day
48	3	14	..... hrs. ..... min.

9. Birthplace: Frederick, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Agriculture

FATHER 12. Name: York.
13. Birthplace

MOTHER 14. Maiden name: York.
15. Birthplace

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 9, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Frederick, Md.

18. Funeral director: M. R. Eichelberger & Son
Address: Frederick, Md.

19. Mar. 5 1945 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 1945 at 3:55a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 1944, to March 5 1945
and that I last saw him alive on March 4 1945

	DURATION
Immediate cause of death: Acute bronchopneumonia	48 hrs.
Due to:	
Due to:	
Other conditions: General paralysis of the insane	3 years

(Incinde pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 3-5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-1) ✓

02746

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County CARROLL

City or town WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 YEARS

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CARROLL

City or town WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 WILLIS ST.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MARY C. HARBAUGH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife EZRA W. HARBAUGH

6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) OCTOBER 7, 1898

8. AGE: Years	Months	Days	If less than one day
46	4	27	hrs. min.

9. Birthplace CARROLL COUNTY, MARYLAND (Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER — 12. Name JOHN C. NEWMAN

13. Birthplace MARYLAND

MOTHER — 14. Maiden name ALLIE BOWMAN

15. Birthplace MARYLAND.

16. Informant E. W. HARBAUGH

Address WESTMINSTER, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 3/8/45 (month) (day) (year)

Cemetery or crematory KRIDERS CEMETERY

Location NEAR WESTMINSTER, MD.

18. Funeral director J. FRANCIS REESE

Address WESTMINSTER, MD.

19. 3/6 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 6, 1945, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20 1944 to March 6 1945

and that I last saw h... alive on March 6 1945

Immediate cause of death	DURATION
Carcinoma of Lungs —	2 Mos
Due to Intestinal Carcinoma of Liver —	3 wks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hunter Bowman (M.D.) M. D. or other

Address Westminster Md. Date signed 3/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

02747

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Carrie H. Hare.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Isaac Hare

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): June 16 - 1866

8. AGE:	Years	Months	Days	If less than one day
	78	9	15	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

MOTHER FATHER

12. Name: John L Nott

13. Birthplace: Maryland

14. Maiden name: Rebecca Fowble

15. Birthplace: Maryland

16. Informant: Mr Ezel Trump

Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 3/45 (month) (day) (year)

Cemetery or crematory: Grave Run

Location: Balto Co

18. Funeral director: Edw C Tipton

Address: Hampstead Md

19. Apr. 2 1945 (Date rec'd by registrar) Mrs W P S Penner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 1945 at 9 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 4 1941 to March 31 1945 and that I last saw h alive on March 31 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Cystitis - Sebastic Cardio Renal Pancreatic Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: Joseph C. Buck MD M. D. or other

Address: Hampstead Md Date signed: 4/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

02748

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Edward Hayes

3.(b) Social Security Number 212-03-3852

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Blanche Zeigler

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1879

8. AGE: Years	Months	Days	If less than one day
65	10	5	hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Store Retail

FATHER 12. Name Edward Thomas Hayes

13. Birthplace Balto. Md.

MOTHER 14. Maiden name Almira Tibbles

15. Birthplace Balto Md.

16. Informant Mrs Blanche Hayes

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 11, 1945 (month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Sykesville, Md.

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. May 10 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1945, at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 42 to March 8 1945 and that I last saw h alive on March 7 1945

Immediate cause of death	DURATION
Tuberculosis of the Larynx	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Brummitt M. D. or other

Address Sykesville Md. Date signed 3-16-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

02749

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs. 1 mo. 26 da.

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 11 yrs. 1 mo. 26 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4800 East Pleasant View Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ADELINE A. W. HOLMES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: (unknown) Holmes

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 15, 1868

8. AGE: Years	Months	Days	If less than one day
76	11	18	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: John F. Walters

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Margaret Brown

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 6-45 (month) (day) (year)

Cemetery or crematory: London Pk. Cem

Location: Frederick Rd.

18. Funeral director: John L. Mullen

Address: 2334 Jefferson St.

19. 3/5 1945 (Date rec'd by registrar) R. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2, 1945, at 12.15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1, 1945 to March 2 1945

and that I last saw her alive on March 1st, 1945

Immediate cause of death	DURATION
Hypertensive Cardio-vascular Disease	11 yrs.
Due to	
Due to	
Other conditions: Psychosis with cerebral Arteriosclerosis	11 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

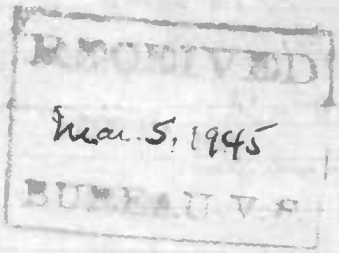
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Ward M. Rea M.D. M. D. or other

Address: Sykesville, Md. Date signed 3-2-45


RECEIVED
Mar. 5, 1945
BUREAU V-5

Evidence for change of age is shown on FILM No. G 9 4 MAY 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02750 Reg. Dist. No. 70

1. PLACE OF DEATH:
County Carroll
City or town Taneytown R.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Mary J. Houck

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

B.(b) Name of husband or wife William Houck
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 5, 1867

8. AGE: Years	Months	Days	If less than one day
77 - 78	11	25	hrs. min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name Frederick Ohler
13. Birthplace Md

MOTHER
14. Maiden name Mary Sherb
15. Birthplace Md

18. Informant Wm. Houck
Address Taneytown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 6, 1945 (month) (day) (year)
Cemetery or crematory St. Joseph's
Location Taneytown, Md
18. Funeral director Leo F. Sauerhammer
Address Taneytown, Md.

19. March 5 1945 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 2 1945, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 1945, to Mar 2 1945 and that I last saw her alive on March 2 1945

Immediate cause of death	DURATION
Cardio Bronchitis	
Due to Myocarditis, Chronic	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. H. Legg M. D. or other
Address Union Bridge Date signed 3-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02751 74

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2611 Greenmount Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Annie Johnson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Johnson, deceased
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 24, 1853

8. AGE: Years	Months	Days	If less than one day
91	10	7	..... hrs. ..... min.

9. Birthplace: Boston, Massachusetts (Town, county, and state)
10. Usual occupation: Factory worker
11. Industry or business

FATHER
12. Name: Albert Henry Chase
13. Birthplace: New Hampshire

MOTHER
14. Maiden name: Mary Ann Barrows
15. Birthplace: Maine

16. Informant: Mrs. Alvin Fowble, landlady
Address: 2611 Greenmount Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 5 1945 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Balto. Md.

18. Funeral director: Williams Cook Inc.
Address: 1217 St. Paul St.

19. Mar. 1 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 1945, at 6 01 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 31 1945 to March 1 1945 and that I last saw her alive on Feb. 28 1945

Immediate cause of death	DURATION
Fracture of rt. neck of femur	36 hrs.
Due to	
Due to	
Other conditions: Senile Psychosis. (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 2-27-45
Where did injury occur? (City or town) Sykesville (County) Carroll (State) Md
Injured at home, farm, industry, public place (where?): Hospital.
Means of injury: Fell on floor. Injured at work? No.

23. SIGNATURE: Edward F. Kernan M. D. or other
Address: Sykesville, Md. Date signed 3-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

02752

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Westminster

County ..... Carroll Co Md

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 68 yrs

Hospital, institution, or street address where death occurred: 20 E. Green St.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster (If outside city or town limits, write RURAL and give nearest town)

Street No. 20 E. Green St. (If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Annie Imedora Johnson

3.(b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widower

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 2 1853

8. AGE: Years	Months	Days	If less than one day
89	9		..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER 12. Name Samuel Radcliffe

13. Birthplace Md

MOTHER 14. Maiden name Anne Gasenelt

15. Birthplace Md

16. Informant Francis Helm

Address 20 East Green St

17. (Burial, cremation, or removal. Which?) Burial Date thereof March 4/46 (month) (day) (year)

Cemetery or crematory St Johns Cemetery

Location Ellicott City Howard Co Md

18. Funeral director Easton Sons

Address Ellicott City Md

19. 3/1/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1- 1945 at 2:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 1- 1945 to Mar 1- 1945 and that I last saw her alive on Mar 1- 1945

Immediate cause of death	DURATION
acute cardiac dilatation	2 hrs
Due to Chronic Myocarditis	2 yrs
Due to Chronic arteriosclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas R Foody MD M. D. or other

Address Westminster Md Date signed 3/1/45

Evidence for change of name of deceased is shown on FILM No. G 97 JUL 28 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02753

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 26 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Federalsburg,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME fossil FOLLIS SHERREFIELD JOHNSON

3.(b) Social Security Number 218-05-8236

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1907

8. AGE: Years	Months	Days	If less than one day
37	10	8	hrs. min.

9. Birthplace: Federalsburg, Md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown

FATHER
12. Name: Aron Johnson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ruth Phillips
15. Birthplace: Maryland

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 7, 1945 (month) (day) (year)
Cemetery or crematory: Federalsburg
Location: Federalsburg Md
18. Funeral director: C. Harry Weber
Address: Sykesville, Md.

19. 3/3 (Date rec'd by registrar) 19 45 Albert R. Shankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 19 45 at 3.15P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov., 5, 19 44 to Mar., 3, 19 45 and that I last saw him alive on March 3, 19 45

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Feb. 1941
Due to:
Due to:
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 3/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02754

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo's, 19 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1534 McElderry Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Hilda Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb., 19, 1929

8. AGE:	Years	Months	Days	If less than one day
	16	0	18	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: at school

FATHER — 12. Name: Norman Jones

FATHER — 13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Unknown Ruth Bailey

MOTHER — 15. Birthplace: Baltimore, Md.

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 13-1945 (month) (day) (year)

Cemetery or crematory: St. John's

Location: Calvert Co. Md.

18. Funeral director: Robert E. Williams

Address: 1515 McElderry St

19. 3/9 (Date rec'd by registrar) 19 45 Albert R. Hamilton Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9, 19 45 at 4.20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18, 19 44 to March 9, 19 45 and that I last saw her alive on March 9, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 3/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02755

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Hewryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: New route Hewryton Sanatorium

How long in hospital or institution? Died on arrive

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1028 N. Stricker St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Robinson Jones

3.(b) Social Security Number 215-18-6469

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Married

6.(b) Name of husband or wife: Lucille Jones

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 16 1921

8. AGE: Years 23 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Va (Town, county, and state)

10. Usual occupation: None Post Office

11. Industry or business

FATHER — 12. Name: Warner Jones

13. Birthplace: Northumberland Co Va

MOTHER — 14. Maiden name: Melissa Campbell

15. Birthplace: Northumberland Co Va

16. Informant: Melissa Jones

Address: 1028 N. Stricker St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 27-1945 (month) (day) (year)

Cemetery or crematory: Lottsburg Va

Location: Northumberland Co Va

18. Funeral director: Va Brooks Russell

Address: 1463 N. Carey St

19. 3/23 1945 (Date rec'd by registrar) Albert B. Swan Jr. Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23 1945 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Shovel, Deputy Medical Examiner M. D. or other

Address: Mechanicsville Md Date signed: 3/23/45

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

02756

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years 11 months, 11 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 28 years, 11 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Brunswick
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Clara E. Kasey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: William Kasey
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 7, 1872

8. AGE: Years	Months	Days	If less than one day
72	6	12	..... hrs. ..... min.

9. Birthplace: West Virginia
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:
FATHER 12. Name: George Shriver
FATHER 13. Birthplace: West Virginia
MOTHER 14. Maiden name: Rosie Cook
MOTHER 15. Birthplace: West Virginia
16. Informant: Hospital Record
Address: Springfield State Hospital
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 22, 1945 (month) (day) (year)
Cemetery or crematory: Berkley Springs
Location: Berkley Springs, W. Va.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19. Mar. 19 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1945 at 12.05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1942 to March 19 1945 and that I last saw her alive on March 19 1945

	DURATION
Immediate cause of death: coronary occlusion	13 days
Due to: arteriosclerosis of coronary arteries	7 years
Due to:	
Other conditions: schizophrenia paranoid type	28 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene Hitchman M.D.
M. D. or other
Address: Springfield State Hosp. Date signed: 3-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02757

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Millers, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Millers
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Eliza Jane Kerchner

3.(b) Social Security Number: None

4. Sex: Femal
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: George W Kerchner (Deceased)
6.(c) If alive, give age: ____ years
7. Birth date of deceased (mo., day, yr.): May 20, 1866
8. AGE: Years 78 | Months 9 | Days 20 | If less than one day: ____ hrs. ____ min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business:
FATHER 12. Name: Jeremiah Krebs
13. Birthplace: Penna.
MOTHER 14. Maiden name: Anna Mary Miller
15. Birthplace: Penna.
16. Informant: Mrs. Avan Redding
Address: Millers Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 13 1945 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester, Md
18. Funeral director: Jacob Whiteford Sons
Address: Manchester, Md
19. Mar. 12 1945 (Date rec'd by registrar) Mrs. W. R. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10th 19 45 at 1.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 19 45 to March 10 19 45 and that I last saw her alive on March 9 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	4
Due to: Stroke	6
Due to:	
Other conditions: Myocardial degeneration (Include pregnancy within 3 months of death)	

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. L. Sohler M.D. M. D. or other
Address: Manchester Md Date signed: March 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20-a)

CERTIFICATE OF DEATH

02758

Reg. Diat. No. 84

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Minnie Howe Kinsey

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~or wife~~: William Kinsey

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 13 - 1865

8. AGE:

Years	Months	Days	If less than one day
79	11	3	hrs. min.

9. Birthplace: Maitland, Penna. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: William Howe

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Sarah Mohler

15. Birthplace: Pennsylvania

16. Informant: William Kinsey

Address: New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 19-1945 (month) (day) (year)

Cemetery or crematory: Shellsville Cemetery

Location: Bedford County, Pa.

18. Funeral director: M. O. Hartle & Son

Address: Union Bridge & New Windsor, Md.

19. March 18 1945 Ernest Bunty Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1945 at 11:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1944 to Mar 15 1945 and that I last saw h~~er~~ alive on March 15 1945

	DURATION
Immediate cause of death: Chronic Ulceration Cecitis	1 yr
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James I. Hood M. D. or other

Address: New Windsor Md. Date signed: 3/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-L)

CERTIFICATE OF DEATH

02759

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 yrs. 1 mo. 1 da.

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 31 yrs. 1 mo. 1 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3718 East Lombard Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CAROLINE M. KURTZ

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: (unknown) KURTZ

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 23 1883

8. AGE: Years	Months	Days	If less than one day
61	7	10	hrs. min.

9. Birthplace: Baltimore Maryland

(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: John M. Weiss

13. Birthplace: Germany

MOTHER — 14. Maiden name: Elizabeth Uhl

15. Birthplace: Baltimore, Maryland.

16. Informant: Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/45 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: north end Rose St

18. Funeral director: Blaum & Hoffmann

Address: 1639 N Broadway

19. 3/5/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2, 1945, at 7.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 28, 1945, to Mar. 2 1945 and that I last saw her alive on March 2, 1945

	DURATION
Immediate cause of death: Lobar Pneumonia	3 days
Due to:	
Due to:	
Other conditions: Fibrous pulmonary Tb	30 yrs.
Paranoid Condition	31yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Maud M. Rees M.D. M. D. or other

Address: Sykesville, Md. Date signed: 3-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

CERTIFICATE OF DEATH

02760

Reg. Dist. No. 81

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Ada C Leese

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 18, 1875

8. AGE: Years	Months	Days	If less than one day
70	2	3	..... hrs. ..... min.

9. Birthplace: Manchester Md

(Town, county, and state)

10. Usual occupation: House work

11. Industry or business

FATHER 12. Name: unknown (adopted)

13. Birthplace —

MOTHER 14. Maiden name: Unknown (adopted).

15. Birthplace

16. Informant: J. R. L. Wink

Address: Manchester. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-24-45 (month) (day) (year)

Cemetery or crematory: cemetery

Location: Manchester Md

18. Funeral director: Jacob Winks Sons

Address: Manchester Md

19. March 22 1945 (Date rec'd by registrar) Lewis E. Pfaff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1945, at 8:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1945, to Mar 21 1945

and that I last saw h...v... alive on Mar. 21 1945

Immediate cause of death	DURATION
Congestive Peelosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: I. H. Legg M. D. or other

Address: Union Bridge Date signed 3/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02761

CERTIFICATE OF DEATH

Reg. Diat. No. 83

1. PLACE OF DEATH:
County: Carroll
City or town: Rural---Gist
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural---Gist
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D.--Sykesville
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ALBERT S. LINDSAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Irene Lindsay
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept. 25. 1870

8. AGE: Years	Months	Days	If less than one day
74	6	3	hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Farmer(retired)
11. Industry or business
FATHER 12. Name: Levi Lindsay
13. Birthplace: Maryland
MOTHER 14. Maiden name: Lucinda Hooper
15. Birthplace: Maryland
16. Informant: Mr. Frank Lindsay
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-31-45 (month) (day) (year)
Cemetery or crematory: Taylorsville
Location: Taylorsville, Carroll Co. Md.
18. Funeral director: C.M.Waltz
Address: Winfield, Md.
19. March 30 19 45 (Date rec'd by registrar) Edna M. Hewitt Deputy Clerk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28, 1945 at 11:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1945 to March 28 1945
and that I last saw him alive on March 28 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 da.
Due to: arteriosclerosis	several yrs.
Due to:	
Other conditions: fracture Left Femurus Fall down steps at Home 3/8/45	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Glenn Sprecher M. D. or other
Address: Westminster Date signed: 3/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02762 74
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 27 days
Hospital, institution, or street address where death occurred:
Maryland Tbc. Sanatorium
How long in hospital or institution Colored Branch(Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil Co.
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Booth St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME HARRY LEE MANNS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1921

8. AGE: Years	Months	Days	If less than one day
23	10	12	hrs. min.

9. Birthplace Martinsville, Va.
(Town, county, and state)
10. Usual occupation laborer
11. Industry or business unknown
FATHER 12. Name William Manns
13. Birthplace Va.
MOTHER 14. Maiden name Nanny Histon
15. Birthplace VA.
16. Informant Reuben Hoffman, M.D.
Address Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/9/45 (month) (day) (year)
Cemetery or crematory Mt. Calvary
Location
18. Funeral director CHARLES W. COOLIDGE
Address 512 W. Conkolleton Ave.
19. 3/6 (Date rec'd by registrar) 19 45 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1945 at 1:P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7, 1944 to mar. 6 1945 and that I last saw him alive on Mar. 6, 1945

	DURATION
Immediate cause of death Pulmonary Tuberculosis	Oct. 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other
Address Henryton, Md. Date signed 3/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 64

02763

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll Co

City or town Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural near Westminster Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bachmans Valley

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clayton Henry Miller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1944

8. AGE: Years	Months	Days	If less than one day
	10	25	hrs. min.

9. Birthplace Westminster R.D. Carroll Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name J. Emmert Miller

13. Birthplace Jackson township York Co. Pa.

MOTHER 14. Maiden name Ruth Evelyn Beer

15. Birthplace Sunbury Pa.

18. Informant J. Emmert Miller

Address Westminster R.D. Carroll Co. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12 '45 (month) (day) (year)

Cemetery or crematory Pleasant Hill Church of Brethren

Location Tyrone Grove Pa.

18. Funeral director J. S. Myers & Son

Address Westminster Md.

19. 3/5 (Date rec'd by registrar) 1945 H. Bloodsworth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945 at 5:30 P.M. Prior to

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Status Thymicus Lymphaticus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lewis T. Marsh Deputy Medical Examiner M. D. or other

Address Lewistown Md Date signed 3/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02764

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months.
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 207 Cross Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: THEODOSIA ERNESTINE MURRAY

3.(b) Social Security Number: 212-16-1385

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 15, 1922

8. AGE: Years	Months	Days	If less than one day
22	7	14	..... hrs. ..... min.

9. Birthplace: Chestertown, Md.
(Town, county, and state)

10. Usual occupation: Packer in Food Plant

11. Industry or business

FATHER
12. Name: William T. Murray
13. Birthplace: Quacker Neck, Md.

MOTHER
14. Maiden name: Sarah Harmon
15. Birthplace: Galena, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial
(Burial, cremation, or removal, Which?)
Date thereof April 2, 1945 (month) (day) (year)
Cemetery or crematory: Chestertown
Location: Chestertown, Md.

18. Funeral director: Marvin T. Williams
Address: Chestertown, Md.

19. 3/29 (Date rec'd by registrar) 19 45 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29, 19 45 at 5.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept., 29, 19 44 to March 29, 19 45
and that I last saw her alive on March 29, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed 3/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02765

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 23 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 7 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1200 Valley Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Edward Page

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): April 14, 1871

8. AGE: Years	Months	Days	If less than one day
73	11	3	hrs. / min.

9. Birthplace: Chicago, Illinois (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 20, 1945 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cemetery
Location: Sykesville, Md.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19. Mar 22 1945 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17, 1945, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 8, 1944, to March 17, 1945, and that I last saw him alive on March 17, 1945.

	DURATION
Immediate cause of death: Arteriosclerosis, prior to July 1944	
Due to: Cerebral thrombosis	6 hours
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	1 year

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M.D. or other
Address: Sykesville, Maryland Date signed: 3-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

02766 77

Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Hampstead Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hampstead Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ada D. Pennington.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Harry H. Pennington

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): February 25, 1879

8. AGE:

Years	Months	Days	If less than one day
66	0	29	hrs. min.

9. Birthplace: Manchester Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home!

FATHER 12. Name: George Zimmerman

13. Birthplace: Maryland

MOTHER 14. Maiden name: Rosanna Shantzbaugh

15. Birthplace: Maryland

16. Informant: H. H. Pennington

Address: Hampstead, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 27/45 (month) (day) (year)

Cemetery or crematory: Hampstead

Location: " Md

18. Funeral director: Edw A Tipton

Address: Hampstead Md

19. Mar 26 1945 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 1945, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h.er alive on March 23 1945

Immediate cause of death	DURATION
Coronary Occlusion	Suddenly
Due to: Chronic Myocarditis	?
Due to:	
Other conditions	

(Ineinde pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: Joseph E. Buck M.D. (M. D. or other)

Address: Hampstead Md Date signed 3/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-5)

02767

CERTIFICATE OF DEATH

Reg. Dist. No. 7-4

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs - 8 mos - 13 days

Hospital, institution, or street address where death occurred: Springfield state Hospital

How long in hospital or institution? 7 yrs - 8 mos - 13 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)

Street No.: 426 Willard Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: — ✓

3. (a) FULL NAME: THOMAS WESLEY PERRY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 13, 1916

8. AGE: Years: 28 | Months: 9 | Days: 18 | If less than one day: ... hrs. ... min.

9. Birthplace: Bethesda, Md. (Town, county, and state)

10. Usual occupation: Caddy.

11. Industry or business: —

FATHER — 12. Name: Boyd Perry

13. Birthplace: Unk.

MOTHER — 14. Maiden name: Virginia Sweet

15. Birthplace: Virginia

16. Informant: Records of Springfield

Address: State Hosp., Sykesville, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar. 6, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Bethesda, Md.

18. Funeral director: L. E. P. Funeral

Address: Bethesda, Md.

19. Mar. 6 1945 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1945 at 11 1/2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1943, to March 3 1945

and that I last saw him alive on March 3 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2+ yrs.
Due to	
Due to	
Other conditions: Mental Deficiency (Include pregnancy within 3 months of death)	

Major findings of operation: ... Date of op. ...

Autopsy results: none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Edward F. Kerman M. D. or other

Address: Sykesville, Md. Date signed: 3-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
MAR 12 1945
BUR U V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02768

Reg. Diat. No. 83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural---Woodbine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural----Woodbine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: War #1

3.(a) FULL NAME: HARRY M. POWERS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Unknown (Single)

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 28, 1888

8. AGE: Years	Months	Days	If less than one day
57	11	6	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Edward Powers
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Waltman
15. Birthplace: Maryland

16. Informant: Family Records
Address: Du Bois

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3--6--45 (month) (day) (year)
Cemetery or crematory: Morgan Chapel
Location: Day, Carroll Co. Maryland

18. Funeral director: C.M. Waltz
Address: Winfield, Md.

19. March 6 19 45 (Date rec'd by registrar) Edna M. Hewitt Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4th 1945, at — M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Probably Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: James T. Hood Deputy Medical Examiner M. D. or other
Address: Westminster Md. Date signed 3/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-L)

02769

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 7 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Talbot
City or town: Sherwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: VIRGINIA PRITCHARD

3. (b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	col.	married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 15, 1903

8. AGE: Years: 41 | Months: 5 | Days: 20 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Kings Georges County, Va. (Town, county, and state)

10. Usual occupation: Worker in Canning Factory

11. Industry or business

FATHER
12. Name: Henry Bolden
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Uninown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 13, 1945 (month) (day) (year)
Cemetery or crematory: St. Lukes Cemetery
Location: Sykesville, Md.

18. Funeral director: C. Harry Weer
Address: Sykesville, Md.

19. March 7, 1945 (Date rec'd by registrar) Albert R. Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 1945, at 10:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 30, 1944 to March 7, 1945 and that I last saw her alive on March 7, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 3-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02770

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 15 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium, Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 534 W. Cross Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: DELORES ELLA MAY PROPHET

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1933

8. AGE:

Years	Months	Days	If less than one day
11	10	26	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER

12. Name: James Prophet

13. Birthplace: South Carolina

MOTHER

14. Maiden name: Lola Gray

15. Birthplace: Spartanburg, S.C.

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 24th/45 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Brooklyn, Md.

18. Funeral director: E. Roy O'Wieson

Address: 1000 Brantley Ave.

19. March 21, 19 45 (Date rec'd by registrar) Albert R. Brandhorst Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21, 1945, at 6:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6, 1944 to March 21, 1945 and that I last saw her alive on March 21, 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	9/15/44
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 3-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02771

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 620 Saratoga St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SHELLY MARY ROSS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: John Ross
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4, 1906

8. AGE: Years: 39 | Months: 0 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: Greenspring, N.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Willie York
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mary Brown
15. Birthplace: Greenspring, N.C.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/15/45 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Mt. Winans, Md.

18. Funeral director: Mrs Katie Williams
Address: 322 N. Schroeder St.

19. March 11, 1945 (Date rec'd by registrar) Albert R. [illegible] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11, 1945, at 5:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 26, 1945 to March 11, 1945 and that I last saw her alive on March 11, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1940
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D., or other
Address: Henryton, Md. Date signed: 3-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

02772

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural near Westminster Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All his life
Hospital, institution, or street address where death occurred:
Uniontown
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Uniontown
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edgar Howell Schaeffer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife Lizzie Wantz
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1869

8. AGE: Years	Months	Days	If less than one day
75	11	6	hrs. min.

9. Birthplace Westminster R.D. Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Jeremiah Schaeffer
13. Birthplace Md.

MOTHER
14. Maiden name Alice V. Bush
15. Birthplace Md.

16. Informant Russell W. Schaeffer
Address Westminster R.D. Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 4/13/45 (month) (day) (year)
Cemetery or crematory Baker Cemetery
Location Rural near Westminster, Md.

18. Funeral director C. E. Myers Jr.
Address Westminster, Md.

19. 4/5 19 44 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31st 19 45 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 19 43, to March 31st 19 45
and that I last saw h[illegible] alive on March 30th 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J. Stewart M. D. or other
Address Westminster Date signed April 1 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02773

Reg. Dist. No. 26

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, Institution, or street address where death occurred:

52 E. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 52 E. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME IDA MAY SHEETS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	W.	Married

6.(b) Name of husband or wife Horace C. Sheets

6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1869

8. AGE: Years	Months	Days	If less than one day
75	3	13	....hrs. ....min.

8. Birthplace Shippensburg Cumb. Co. Pa.
(Town, county, and state)

10. Usual occupation home — wife

11. Industry or business

FATHER 12. Name David Kauffman

13. Birthplace Shippensburg Pa.

MOTHER 14. Maiden name Martha (?) Kauffman

15. Birthplace Shippensburg Pa.

18. Informant Mr. Horace C. Sheets

Address 52 E. Main St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 10 1945 (month) (day) (year)

Cemetery or crematory Spring Hill Cemetery

Location Shippensburg Pa.

18. Funeral director J. E. Myers, Jr.

Address Westminster, Md.

19. 3/6 1945 E. Reese Wilhelm Jr. M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1945, at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1940 to 3-7-1945 and that I last saw her alive on March 7, 1945

Immediate cause of death	DURATION
Myocardial degeneration	3 yrs
Due to arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Reese Wilhelm Jr. M.D. M. D. or other

Address Westminster Md. Date signed 3/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ma)

CERTIFICATE OF DEATH

02774

Reg. Dist. No. 75

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:
County: Carroll
City or town: Millers, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Millers, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME August F. Shilke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ~~Aug~~ Mar 15-1873

8. AGE:	Years	Months	Days	If less than one day
~~About~~	71	—	10	..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Frederick Shilke
13. Birthplace Md

MOTHER
14. Maiden name Sophia Haines
15. Birthplace Md

16. Informant Otto Shilke
Address Glen Rock, Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 29/45 (month) (day) (year)
Cemetery or crematory Linebord
Location Carroll Co Md

18. Funeral director Edw C Tipton
Address Hampstead Md

19. Mar. 28 1945 Wm. H. R. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945 at 2:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1945 to March 23 1945 and that I last saw him alive on March 23 1945

Immediate cause of death	DURATION
Coronary sclerosis	
Coronary thrombosis	6 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. V. Sohler M.D.
M. D. or other
Address Manchester Md Date signed 3-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

02775

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 5 months
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 2 years, 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Smallwood

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Kate R. Espey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 20, 1859

8. AGE: Years	Months	Days	If less than one day
86	1	19	hrs. min.

9. Birthplace: Howard County, Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: John Smallwood
13. Birthplace: Howard County, Maryland

MOTHER
14. Maiden name: Rebecca Hipsley
15. Birthplace: Howard County, Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Mar. 21, 1945 (month) (day) (year)
Cemetery or crematory: London Park Cem.
Location: Balto. Md.
18. Funeral director: Easton Sons
Address: 60 E. Fredericks Ave. Catonsville

18. Mar. 19 1945 (Date rec'd by registrar) C. A. Henry Elwell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19, 1945, at 2:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943, to March 19, 1945
and that I last saw him alive on March 18, 1945

Immediate cause of death	DURATION
Acute bronchopneumonia	48 hrs.
Due to: Arteriosclerosis	15 yrs.
Due to: Coronary sclerosis	3 weeks
Due to: —	
Other conditions: Senile psydhosis, paranoid type	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
Springfield State Hospital M.D. or other
Address: Sykesville, Maryland Date signed: 3-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of date of duration is shown on FILM No. G92 MAR 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02776

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 8 months, 8 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanitorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 822 Ostend Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: OTELIA SMITH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 1, 1925

8. AGE:

Years	Months	Days	If less than one day
19	5	0	hrs. min.

9. Birthplace: Halifax County, Virginia (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Robert Smith
13. Birthplace: Virginia

MOTHER
14. Maiden name: Picolar Miles
15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 4th/45 (month) (day) (year)
Cemetery or crematory: Mt Calvery
Location: Brookland Md
18. Funeral director: Elroy O Wilson
Address: 1000 Brantley Md

19. March 1, 1945 (Date rec'd by registrar) Albert A. Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1, 1945, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21, 1943, to March 1, 1945 and that I last saw her alive on March 1, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	~~Jan. June 1941~~ 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 3-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02777

Reg. Diat. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Rural-Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural-Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ezra D. Spangler

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Sarah J. Myers

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1871

8. AGE: Years	Months	Days	If less than one day
73	8	20	hrs. min.

9. Birthplace Carroll County, Md.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Samuel Spangler

13. Birthplace Penna.

MOTHER 14. Maiden name Sarah Hahn

15. Birthplace Maryland.

16. Informant Mr. Lake Weant

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 21, 1945 (month) (day) (year)

Cemetery or crematory Baust Cemetery

Location Near Taneytown, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. March 21, 1945 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1945, at 9:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15, 1945, to March 19, 1945 and that I last saw him alive on March 19, 1945

Immediate cause of death	DURATION
Chronic Diffuse Nephritis	5 yrs.
Due to Generalized Arteriosclerosis	10 yrs.
Due to	
Other conditions Chronic Myocarditis	5 yrs.
Grippe, Acute Bronchitis	4 days.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D.
M. D. or other

Address Taneytown, Md. Date signed 3/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02778

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll Co.
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? almost all her life
Hospital, Institution, or street address where death occurred:
100 Penna. Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 100 Penna Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Marjorie Stultz Stambaugh

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife John A. Stambaugh
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 22nd 1905

8. AGE: Years	Months	Days	If less than one day
39	9	9	..... hrs. ..... min.

9. Birthplace Westminster Carroll Co. Md. (Town, county, and state)
10. Usual occupation Home - wife
11. Industry or business
FATHER 12. Name Jesse Stultz
13. Birthplace Westminster, Md.
MOTHER 14. Maiden name Carrie R. Stultz
15. Birthplace Westminster Md
16. Informant Mrs John W. Bankert
Address 106 Penna. Ave. Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/14/45 (month) (day) (year)
Cemetery or crematory Winders Cemetery
Location Mews Westminster Md.
18. Funeral director J. E. Myers, Jr.
Address Westminster, Md.
19. 3/13 1945 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945, at 9:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1944 to March 11 1945
and that I last saw her alive on March 11 1945

Immediate cause of death	DURATION
Carcinoma Lungs (Metastasis)	Prob 6 Mo.
Due to Carcinoma Left Breast	1942
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Ca L. Breast
Date of op. 1942
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other
Address Westminster Md. Date signed March 13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02779

CERTIFICATE OF DEATH

Reg. Diat. No. 70

1. PLACE OF DEATH:
County: Carroll
City or town: Tyrone
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Westminster Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Albert Starner

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife: Sarah Jane Starner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 22, 1861

8. AGE:	Years	Months	Days	If less than one day
	83	9	19	..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Lucy Ann Young
15. Birthplace: Md

18. Informant: Mrs Elmer J. Wantz
Address: Westminster. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 16, 1945 (month) (day) (year)
Cemetery or crematory: Pleasant Valley
Location: Pleasant Valley Md
18. Funeral director: Ed Dwyer Son
Address: Taneytown Md

19. March 16. 1945 Ethel M Mehring Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14th 1945 at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1945 to March 14th 1945 and that I last saw h... alive on March 14th 1945

Immediate cause of death	DURATION
Lobar Pneumonia	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Luther Bair (M.D.)
M. D. or other
Address: Westminster Maryland Date signed 3/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

02780

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yr., 11 mo., 1 day
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 8 yr., 11 mo., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George W. Taylor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Ada Taylor
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 17, 1884

8. AGE: Years	Months	Days	If less than one day
60	11	15	hrs. min.

9. Birthplace: Frederick County, Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: John William Taylor
13. Birthplace: Harrisonburg, Virginia

MOTHER
14. Maiden name: Jane R. Kern
15. Birthplace: Lovettsville, Virginia

19. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/5/45 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown Md
19. Funeral director: H.K. Coffman
Address: Hagerstown Md.

19. Mar. 2 1945 (Date rec'd by registrar) C. Henry Wood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 1945 at 3:05a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to March 2 1945 and that I last saw him alive on March 1 1945

Immediate cause of death	DURATION
Cerebral thrombosis	12 hrs.
Due to: Syphilis, prior to	1934
Due to:	
Other conditions: General paralysis of the insane	11 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed 3-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02781

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 4 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1010 Argyle Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: RUTH TUNNING

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7, 1908

8. AGE: Years	Months	Days	If less than one day
36	11	15	hrs. min.

9. Birthplace: Salem, Virginia (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:
FATHER — 12. Name: Austin Tunning
13. Birthplace: Franklin, Va.
MOTHER — 14. Maiden name: Rebecca Parker
15. Birthplace: Franklin, Va.
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-27-45 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Cedar Hill, Md.
18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Ave.
19. March 22, 1945 (Date rec'd by registrar) Albert R. Sowers Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22, 1945 at 7:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18, 1944 to March 22, 1945 and that I last saw her alive on March 22, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 3-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02782

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 5 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1618 Riggs Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
CHARLES FRANKLIN WARD

3. (b) Social Security Number
217-07-3249

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife: Julia Ward
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Nov., 12, 1892

8. AGE: Years	Months	Days	If less than one day
52	3	27	hrs. min.

9. Birthplace: Frederick, Md.
(Town, county, and state)
10. Usual occupation: Waiter
11. Industry or business: Unknown

FATHER
12. Name: John Ward
13. Birthplace: Frederick, Md.

MOTHER
14. Maiden name: Minnie Ward
15. Birthplace: Frederick, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 15-45 (month) (day) (year)
Cemetery or crematory Mt Calvary
Location Ann Arundell County
18. Funeral director Geo G. Kelson
Address 1303 Presstman St

19. 3/11 (Date rec'd by registrar) 19 45 Albert R. Swanborn deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, [illegible] 19 45 at 11.00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6, 19 44, to March 11, 19 45 and that I last saw him alive on March 11, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 24, 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M. D.
M. D. or other
Address Henryton, Md. Date signed 3/11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02783

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: FINKSBURG, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: FINKSBURG
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: JAMES SHERLEY WARD

3.(b) Social Security Number: 219-20-1724

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: MATILDA E. FRANTZ

6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): JANUARY 3, 1919

8. AGE:

Years	Months	Days	If less than one day
26	2	23	hrs. min.

9. Birthplace: CARROLL COUNTY, MD.
(Town, county, and state)

10. Usual occupation: AIRPLANE MECHANIC

11. Industry or business

FATHER
12. Name: HARVEY R. WARD
13. Birthplace: MD.

MOTHER
14. Maiden name: ELEANOR CRESS
15. Birthplace: MD.

16. Informant: MRS. JAMES S. WARD
Address: FINKSBURG, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 3/29/45 (month) (day) (year)

Cemetery or crematory: MOUNT PEACE CEM.

Location: MINERSVILLE, PA.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 3/27 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 26 19 45, at 6 A.M.

21. I CERTIFY, that death occurred on the date above stated: that I attended deceased from February 19- 19 45, to March-26 19 45

and that I last saw h.. alive on March 25- 19 45

Immediate cause of death: Tuberculosis Pulm. (Chr.)

Due to: Asthma

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: 10 yrs. / 3-22-45

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. C. Jennette, Jr., M. D. or other

Address: Westminster Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02784

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 27 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 727 Baker St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: PHILLIS ROSETTA WATKINS

3.(b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 5, 1928

8. AGE:

Years	Months	Days	If less than one day
16	3	12	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER — 12. Name: Charles Watkins

FATHER — 13. Birthplace: Chains, Maryland

MOTHER — 14. Maiden name: Nannie Franklin

MOTHER — 15. Birthplace: Dunkirk, Maryland

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: Mar-20-45 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore City.

18. Funeral director: Geo. L. Kelson

Address: 1303 Pressman St.

19. March 17, 19 45 (Date rec'd by registrar) Albert R. Swanbaker Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17, 1945, at 7:00A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18, 1945, to March 17, 1945.

and that I last saw her alive on March 17, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1/1/45
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 3-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

02785

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 21 O'Brien Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SAMUEL WATKINS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Dorothy Watkins
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): June 13, 1907

8. AGE: Years	Months	Days	If less than one day
37	8	17	....hrs. ....min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)
10. Usual occupation: Laundry Worker
11. Industry or business: Unknown
FATHER 12. Name: Samuel Watkins
FATHER 13. Birthplace: Annapolis, Md.
MOTHER 14. Maiden name: Eleanor Colbert
MOTHER 15. Birthplace: Annapolis, Md.
16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/5/1945 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetary
Location: West End Ext.
18. Funeral director: Ethel Hicks
Address: 45 North West. Annapolis, Md.
19. 3/2 (Date rec'd by registrar) 19 45 Albert R. Swanbland Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2, 19 45 at 2.45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 22 19 45 to March 2, 19 45 and that I last saw him alive on March 2, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1/2/45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 3/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: (Please) write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02786

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1yr. 4 mos., 28 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium (Colored)

How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 810 N. Woodyear Street
(If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME: DELORES WILKINS

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 4, 1937

8. AGE: Years: 8 | Months: 0 | Days: 29 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: --

FATHER
12. Name: Ruie Wilkins
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Annie Wilkins
15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 3/8/45 (month) (day) (year)
Cemetery or crematory: Westrem Cem.
Location: Catonsville

18. Funeral director: Mrs. Katie Williams
Address: 322 S. Schroeder St.

19. March 4 19 45 (Date rec'd by registrar) Albert R. Swansbrough deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 19 45 at 7:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 8 19 43, to March 3 19 45 and that I last saw her alive on March 3 19 45

Immediate cause of death	DURATION
Pulmonary tuberculosis	June 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 3-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (d)

CERTIFICATE OF DEATH

02787

Reg. Dist. No. 76

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Agnes M. Wimert

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Joseph D. Wimert

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan. 23 1882

8. AGE: Years	Months	Days	If less than one day
63	2	4	...hrs. ...min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Israel Lilly
13. Birthplace Md.

MOTHER
14. Maiden name Catherine Snyder
15. Birthplace Md.

16. Informant Joseph D. Wimert
Address Westminster Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof March 29-1945 (month) (day) (year)

Cemetery or crematory Baust Church

Location Westminster, Md.

18. Funeral director H. B. Gaylen & Son

Address Westminster

19. 3/27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1945, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1940 to March 27 1945 and that I last saw h.er alive on March 26 1945

Immediate cause of death Diabetes — DURATION 10+ yrs

Due to

Due to

Other conditions Recent amputation of right leg, Lobar pneumonia, Gangrene
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Reese Wilkens M.D.
M. D. or other

Address Westminster Date signed 3/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

62788

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 2 months, 3 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1125 E. Lexington Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: ELIZABETH YOUNG

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept., 3, 1923

8. AGE:

Years	Months	Days	If less than one day
21	6	1	hrs. min.

9. Birthplace: Blackstock, N. C.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Unknown

FATHER
12. Name: Walter Young
13. Birthplace: Blackstock, N. C.

MOTHER
14. Maiden name: Mozell Hood
15. Birthplace: Blackstock, N. C.

16. Informant: Reuben Hoffman. M D.
Address: Henryton, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Mch 5th
(month) (day) (year)

Cemetery or crematory: Monroe N.C.

Location:

18. Funeral director: Thos. O. Wilson

Address: 1000 Brantley Av

19. 3/4 19 45 (Date rec'd by registrar) Albert R. Stevenson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4, 19 45, at 5.25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 31, 19 43, to March 4, 19 45

and that I last saw her alive on March 4, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other

Address: Henryton, Md. Date signed: 3/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15